



# IDAHO DEPARTMENT OF HEALTH & WELFARE

JAMES E. RISCH – Governor  
KARL B. KURTZ – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0036  
PHONE 208-334-6626  
FAX 208-364-1888

September 13, 2006

FILE COPY

Dr. Mark Hollingshead, Administrator  
Surgicare Center of Idaho  
360 East Mallard Drive Suite 125  
Boise, ID 83706

Dear Dr. Hollingshead:

This is to advise you of the findings of the Medicare/State Licensure fire safety survey concluded at Surgicare Center of Idaho on August 31, 2006.

Enclosed is the Statement of Deficiencies/Plan of Correction, form CMS-2567, and a copy of the State fire safety Statement of Deficiencies/Plan of Correction form listing fire/life safety deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

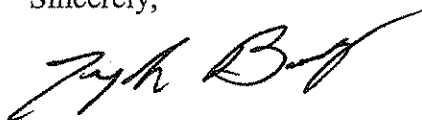
1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.

After you have answered and dated each deficiency, please sign and date each cover page in the spaces provided. Retain one (1) copy of each page and return the originals to this office by **September 26, 2006**.

Dr. Hollingshead, Administrator  
September 13, 2006  
Page 2 of 2

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

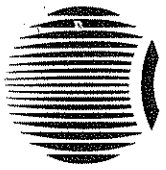
Sincerely,

A handwritten signature in black ink, appearing to read "Taylor Barkley", written in a cursive style.

TAYLOR BARKLEY  
Facility Fire Safety & Construction

TB/mlw

Enclosures



Hollingshead  
Eye Center, P.C.

Mark E. Hollingshead, M.D.

Cataract & Refractive Surgeon

Brian J. McNeel, O.D.

Taylor Barkley  
Facility Fire Safety & Construction  
Department of Health & Welfare  
Bureau of Facility Standards  
PO Box 83720  
Boise, Idaho  
83720-0036

Dear Mr. Barkley:

Enclosed you will find the Statement of Deficiencies/Plan of Correction form that has  
Listed our fire/life safety deficiencies. You will also find on this form the dates and the  
Steps taken to correct the deficiencies. I have kept a copy of this form for my records.  
If you have further questions you may reach me at (208) 386-3306.

Sincerely,

Christi A. Campbell  
Surgicare Center of Idaho, Administrator

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SEP 20 2006  
FACILITY STANDARDS

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 09/12/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13C0001014	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE ASC WING B. WING _____	(X3) DATE SURVEY COMPLETED  08/31/2006
NAME OF PROVIDER OR SUPPLIER <b>SURGICARE CENTER OF IDAHO</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>360 EAST MALLARD DRIVE SUITE 125 BOISE, ID 83706</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  A Fire / Life Safety survey was conducted at Surgicare Center of Idaho on 8/31/2006. The 2000 Existing Edition of the Life Safety Code was utilized for this survey, in accordance with 42 CFR 416.44(b)  The Ambulatory Surgery Center is located on the first floor of a two story Type II (111) structure. Portable fire extinguishers are provided as well as emergency lighting and exit signs. The building has an automatic sprinkler system and is sprinklered throughout. There are two (2) remotely located exit doors leading to the exterior. A one (1) hour rated wall assembly separates the ASC from the other tenants. Procedures performed in the Center are limited to those not requiring general anesthesia.  The survey was conducted by:  Taylor Barkley Health Facility Surveyor  Chris Laumann Health Facility Surveyor	K 000		
K 046	416.44(b)(1) LIFE SAFETY CODE STANDARD  Emergency illumination is provided in accordance with section 7.9. 20.2.9.1, 21.2.9.1  This Standard is not met as evidenced by: A check of emergency lighting on the day of the	K 046		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 046	Continued From page 1 survey (i.e., 8/31/2006) at 9:26 am noted that the emergency lighting was not in accordance to 7.9  Findings included:  The emergency light in the autoclave room did not work. This was witnessed by survey team and facility staff.	K 046	Simplex-Grinnell came out to the facility to replace the emergency lighting unit. It is now operational. Preventive Action - A monthly check will be made to assure proper operation.	9-18-06
K 047	416.44(b)(1) LIFE SAFETY CODE STANDARD  Exits and ways of travel thereto are marked in accordance with section 7.10. 20.2.10, 21.2.10  This Standard is not met as evidenced by: A check of exit signs on the day of the survey (i.e., 8/31/2006) at 9:50 am noted that exit signs were not in accordance with 7.10  Findings included:  Four of six exit lights in the facility did not have the required illumination. This was witnessed by survey team and facility staff.	K 047	Simplex-Grinnell came out to our facility & replaced light bulbs & one battery in the exit lights. All are now functional. Preventive Action - A monthly check will be performed to insure proper operation of exit lights. This will be performed by the Administrator.	9-18-06
K 064	416.44(b)(1) LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided. 20.3.5.2, 21.3.5.2  This Standard is not met as evidenced by: Based upon a visual inspection of the service tag on each portable fire extinguisher during the survey (i.e., 08/31/2006), the facility did not assure that each is being annually inspected as	K 064	Simplex-Grinnell inspected & placed new service tags on the facilities two fire extinguishers. Preventive Action - A quarterly check will be performed to insure the service tag on all fire extinguishers	9-18-06

FORM CMS-2567(02-99) Previous Versions Obsolete

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If continuation sheet Page 2 of 4

is current. This will be performed by the Surgery Administrator.

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K 064	Continued From page 2 required.  Findings Include:  The tag on a portable fire extinguisher indicated it was last serviced/inspected by an outside servicing company/agency in June 2005	K 064		
K 114	416.44(b)(1) LIFE SAFETY CODE STANDARD  Ambulatory health care occupancies are separated from other tenants and occupancies by fire barriers with at least a 1 hour fire resistance rating. Doors in such barriers are solid bonded core wood of 1 1/2 inches or equivalent and are equipped with a positive latch and closing device. Vision panels, if provided in fire barriers or doors, are fixed fire window assemblies in accordance with 8.2.3.2.2.  This Standard is not met as evidenced by: Based on observation on 08/31/2006, it was determined that the facility had failed to maintain the one hour required separation for the ASC.  Findings include:  1. Observation on 08/31/2006 at 9:45 am revealed that in pre-op room #1 there were unsealed penetrations of the fire wall with conduit.  2. Observation on 08/31/2006 at 9:42 am revealed that in pre-op room #2 there were unsealed	K 114	All penetrations were filled by the building maintenance personnel. This included pre-op rooms 1 & 2 & the waiting room. Preventive Action - <del>At whenever a</del> Any work that would involve the surgery fire walls will need to be reviewed prior to penetrating walls. If penetration is deemed necessary then the penetrations will be sealed immediately after work to ensure fire wall integrity. This	9-15-06

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14NE21  
review will be performed  
by the Administrator.

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K 114	Continued From page 3 penetrations of the fire wall with conduit.  3.Observation on 08/31/2006 at 8:55 am revealed that in the waiting room there were unsealed penetrations of the fire wall with conduit.	K 114	Over	9-15-06	

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